V. Specific Population Findings

Data on specific sub-populations of persons living with HIV/AIDS are drawn from several sources. Epidemiologic data and summaries are excerpted from HIV/AIDS Epidemiology Profile for Community Planning 2003, published by the HIV/AIDS Epidemiology Unit of Public Health – Seattle & King County. All other information is derived from data from the 2003 consumer surveys, provider interviews, and focus groups, except where noted. (See Section III, Methods) Italicized quotes have been excerpted from consumer focus group transcripts, provider interviews and narrative sections of the consumer and provider surveys.

Within each sub-population, reports are organized as follows:

1. **Epidemiologic Profile:** A summary of the population-specific data regarding AIDS case status and trends, population size, seroprevalence estimates and subgroup highlights (where appropriate).

2. **Service Trends:** Patterns in overall service utilization, including demographic trends and population-specific needs as identified by consumers and providers.

3. **Service Priorities:** Services that have been identified as priorities for the target population, by consumers themselves and/or by providers with expertise and experience in working with the population. The top ten priorities per sub-population from the consumer survey are listed.

4. **Service Gaps:** Services that consumers and/or providers have identified as deficient, either because the service is not available, not accessible, or is not delivered in a manner consistent with sub-population needs. The top ten service gaps per sub-population from the consumer survey are listed.

5. **Unmet Need for Medical Care:** Quantitative estimates of the number of PLWH in the sub-population who do not meet the definition of being "in medical care", and factors identified by consumers and providers which serve as barriers to utilization of medical care. The definition of "in care" is consistent with the HRSA/UCSF definition of "in care" as evidenced by a CD4 count, viral load test or administration of HAART therapy within the previous twelve-month period. PLWH determined to be "not in care" were those for whom no evidence existed of any of these three clinical markers during the prior year.

(NOTE: All results noted as statistically significant were tested at the $p<.05$ level.)

A. Men who have Sex with Men

"It seems that services for those of us that use them seem to becoming harder to get. I'm grateful for what I get, but I fear for others who are less fortunate." (African American MSM PLWH)

1. Epidemiologic Profile

Men who have sex with men (MSM) were the earliest group affected by HIV/AIDS in King County and continue to bear the largest burden of HIV infections and AIDS diagnoses. In King County, 85% of persons living with HIV/AIDS of known risk are MSM, including MSM who have injected drugs (MSM/IDU). (NOTE: Where appropriate, information on MSM/IDU will be discussed in both this section and Section B, "Injection Drug Users.")

Population sizes: Based on data from a variety of sources, Public Health – Seattle & King County estimates that MSM number between 32,000 and 53,000 in King County, including approximately 2,500-3,800 MSM with histories of injection drug use. There are an estimated 6,300 HIV infected MSM without an IDU history, and an estimated 800 HIV infections county-wide with any history of injection drug use as a reported risk. As of 12/31/2002, 3,584 MSM and 465 MSM/IDU were reported to Public Health and presumed living with HIV or AIDS in King County.

Status and trends in HIV/AIDS cases: Although MSM are still the largest subgroup with AIDS in King County, AIDS case report data show a declining trend in annual HIV diagnoses among MSM beginning in 1994. The proportion of new HIV cases among MSM not injecting drugs decreased from 78% of those with known risk in 1993-95 to 69% in 2000-2002. Non-IDU MSM also dropped from 79% to 69% of AIDS diagnoses in the same time periods. The proportion of HIV diagnoses among MSM/IDU has remained roughly level at 8-9% of all diagnoses with known risk from 1994-2002. The percent of AIDS cases in MSM/IDU was level at 10% for the same time period.

HIV seroprevalence: Assuming the population of MSM without injection drug history is correct, between 13% and 21% of all MSM in King County are infected with HIV. The infection rate is greater among MSM/IDU (between 21% and 32% of MSM/IDU being HIV-infected).

Among MSM, the highest levels of HIV prevalence were generally found in:

- older MSM compared to younger MSM
- MSM with histories of STD's
- MSM/IDU, especially methamphetamine injectors, relative to those with no IDU history
- African-American MSM relative to Whites and others
- men who had sex exclusively with other men rather than both men and women.

Subgroup highlights:

MSM of color: Among men of color currently living with HIV/AIDS, 68% reported male-male sex with or without IDU as a risk factor for HIV. This proportion is lower than among White male PLWH (93% reporting male-male sex). Of male HIV/AIDS cases reported through 2002,

58% of African Americans were MSM or MSM/IDU, compared to 78% of Latinos, 82% of Native Americans, and 80% of Asians/Pacific Islanders.

MSM Injection Drug Users (MSM/IDU): Amphetamine use was reported by 40% of MSM drug injectors, in comparison to 4% of non-MSM drug injectors in unlinked seroprevalence studies at King County drug treatment centers from 1988 through 1997. In an interview study of IDUs conducted in King County from 6/94-5/98, amphetamine was the common injection drug for 33% of MSM injectors compared to 5% of all other injectors. In this same study, the seroprevalence of HIV was 47% in MSM whose primary injection drug was methamphetamine, compared to 14% of MSM who primarily injected other drugs.

2. Service Trends

As in previous years, providers of services to MSM report that the large majority of their clients are White (ranging from 70%-80%, depending on the provider). Providers reported a continued increase in gay men of color, mostly among Hispanic MSM. Providers also noted that they are seeing a rise in younger MSM clients, especially those in their 20's. They reported an increase in newly diagnosed MSM clients over the age of 40, as well as seeing an aging client caseload of MSM PLWH aged 50 and over.

Most of the White MSM clients are residents of Seattle. MSM of color are more likely to reside in South King County, particularly Latino MSM. Providers also reported a significant increase in the percentage of clients who have experienced homelessness, across all races and ethnicities.

As first identified in 1997, providers continue to see high percentages of MSM clients presenting with mental illness and chemical dependency. In particular, providers noted an increasing incidence of severe clinical depression in their MSM clients. Providers noted that a higher percentage of these clients are now taking antidepressants and/or self-medicating. An increasing percentage is also presenting with more severe mental health diagnoses, such as bipolar disease and personality disorders. On the 2003 consumer survey, 59% of White MSM respondents and 40% of MSM of color reported having been diagnosed with a mental illness.

Providers report that a substantial percentage of their MSM clients are current or former substance users, although the number has leveled in the past several years. "Drugs of choice" for these MSM clients appear to be broken down along racial lines. For White MSM, crystal methamphetamine continues to be the main non-injection drug of choice. Almost twice as many White MSM survey respondents reported meth use as did MSM of color (16% versus 9%). For these individuals, meth use is often coupled with Ecstasy. Among African American MSM PLWH, crack cocaine use is more common (14% of MSM of color reporting cocaine use versus 9% of White MSM). Providers whose caseload is primarily composed of MSM/IDU report high levels of multi-drug use among their clients. Alcohol abuse is also is reported as being widespread.

2003 consumer survey data reveal several differences in HIV-related health status between MSM of color and White MSM. MSM of color were significantly more likely than White MSM to report themselves as being HIV+ but not AIDS-disabled (38% versus 29%). Overall, MSM of

color were less likely than White MSM to be taking all forms of HIV medications: antiretrovirals (69% versus 77%), protease inhibitors (43% versus 49%) and medications to treat and prevent opportunistic infections (30% versus 41%). Despite these disparities, the percentage of MSM of color who reported taking one or more forms of HIV-related medications has risen in each succeeding survey year.

Providers of services to MSM noted that access to HIV medications was rarely an issue and/or barrier for their clients. Medical providers noted that compliance with HAART has generally improved during the past several years. However, MSM/IDU clients are more likely to experience adherence challenges than MSM without injection drug use histories. Providers noted that compliance is also a problem with MSM clients in situations where confidentiality is still an issue, such as non-self identified MSM of color in family situations or MSM who are still working but are not "out" about their HIV status in their place of employment.

As in past years, MSM continue to report high utilization of clinical and support services. Continuing a trend first observed in 2001, white MSM exhibited service utilization rates that were lower than MSM of color in most service categories. Of particular note is that White MSM were less likely than MSM of color to report utilization of financial assistance programs, such as grocery vouchers (25% versus 47%), help paying rent (38% versus 52%) and help paying for utilities (29% versus 42%). MSM of color were also more likely to use peer or client advocacy programs than White MSM (41% versus 26%).

3. Service Priorities

MSM survey respondents ranked primary medical care as their highest service priority, followed by dental care, the AIDS Drug Assistance Program, case management, and housing assistance or housing-related services (Table 20).

Table 20. Service Priorities: MSM (n=357; 5 missing responses)

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Ambulatory/outpatient medical care	245	69%
2	Oral health care	226	63%
3	AIDS Drug Assistance Program	221	62%
4	Case management	206	58%
5	Housing assistance/related services	172	48%
6	Emergency financial assistance	160	45%
7	Health insurance	158	44%
8	Food bank/home-delivered meals	123	34%
9	Mental health services	114	32%
10	Psychosocial support	105	29%

Very few significant differences emerged in the ways in which White MSM and MSM of color prioritized services. This is a marked change from 2001 survey responses. White MSM were significantly more likely than MSM of color to prioritize mental health services (36% versus 21%), while MSM of color were more likely than White MSM to prioritize housing services (45% versus 55%).

4. Service Gaps

As with most other populations, MSM PLWH identified emergency financial assistance as the highest service gap. Other highly ranked service gaps for this population include housing services, psychosocial support, alternative therapies, legal assistance and oral health care (Table 21). Within the housing category, a larger gap emerged in help paying rent (20%) than in help finding housing (12%). In the psychosocial support category, one-on-one peer support (17%) was identified as the highest gap, as opposed to support groups or spiritual counseling (both at 8%). Grocery vouchers were rated as a slightly higher emergency financial assistance gap (27%) than was help paying for utilities (22%).

Table 21. Service Gaps: MSM (n=362)

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Emergency financial assistance	127	35%
2	Housing assistance/related services	84	23%
3	Psychosocial support	81	22%
4	Alternative/non-Western therapies	72	20%
5	Legal services	66	18%
6	Oral health care	65	18%
7	Client advocacy	52	14%
8	Mental health services	47	13%
9	Food bank/home-delivered meals	40	11%
10	Referral for health care services	35	10%

MSM were not statistically more likely than other PLWH to identify service gaps in any category. The only category in which an MSM sub-population was more likely to identify gaps was in health education/risk reduction, in which MSM of color were more likely than non-MSM to note lack of access to this service (9% versus 4%).

Data from the 2003 survey were also used to quantify the unmet needs of MSM. This was accomplished by applying the percent of MSM identifying service gaps across the population estimate of 4,049 MSM and MSM/IDU reported to Public Health and presumed living with HIV or AIDS in King County. Analysis indicates that the greatest unmet need for this population exists in the area of emergency financial assistance, with approximately 1,420 MSM being unable to obtain utility and/or grocery voucher assistance. An additional 930 MSM display unmet needs for housing assistance, with the majority of this need being rental assistance. These numbers reflect the increasing percentage of long-term survivors in this population who

are now living on fixed incomes below 200% of FPL (Federal Poverty Level). Approximately 890 MSM have unmet needs for peer counseling, particularly African-American and Latino MSM.

Providers reported that housing continues to be a significant challenge for their MSM clients. This is particularly true for MSM clients who are HIV+, but not AIDS disabled and for clients with histories of incarceration or active substance use issues. The majority of MSM focus group participants (White MSM: n=9; MSM of color: n=7) were in stable housing situations, although many of them expressed concerns about their ability to keep pace with rising rental costs.

Providers noted an overall increase among MSM clients who are seeking more help with financial assistance and insurance income benefits. Growing numbers of MSM clients are entering the system with no income and/or no insurance. Providers reported service gaps for their MSM clients (and clients in general) in accessing Medicaid dental care due to a severe shortage of providers who are willing to accept this form of reimbursement. Additionally, providers noted that coverage for complex procedures such as bridges, crowns and dentures is relatively impossible to secure for their clients. Consumers expressed frustration in navigating the dental care system, reporting extensive delays in accessing even basic dental care. Based on reports from providers, emergency dental appointments are also hard to secure.

5. Unmet Need for Medical Care

> *"My case manager and my financial advocate have been my saviors. After being hospitalized three times this year for AIDS-related illnesses, without their assistance I would be homeless and without insurance to receive the medical care and medications that keep me alive." (White MSM PLWH)*

Ninety-four percent of both White MSM and MSM of color survey respondents reported current utilization of primary care services. Lack of access to primary care was reported by only 2% of MSM survey respondents. However, MSM living outside of Seattle reported having to travel long distances to obtain medical services. Neither consumers nor providers of services to this population reported barriers to accessing HIV/AIDS medications, although providers noted that adherence to with complex dosing regimens remain problematic for many of their clients, and that treatment failures continue, particularly for long-time survivors.

Providers noted that cultural differences may exist for some immigrant MSM of color (particularly Latinos and Asian/Pacific Islanders) regarding utilization of primary care. For some members of these populations, there may be a lack of trust in Western medical care or a cultural norm against seeking medical care unless debilitating clinical illness exists. MSM of color who participated in the "Care Project 2002" consumer interview project were almost twice as likely as White MSM to report having had problems in accessing medical care (8.5% versus 4.3%). The primary reasons given for these problems included a lack of providers of color in the system, language barriers (particularly for monolingual Spanish-speakers) and lack of attention to cultural issues on the part of some service providers.

Access to prescription drugs did not emerge as a significant problem for MSM, but providers noted that medication adherence for MSM of color (particularly Latinos and Asians/ Pacific Islanders) can be complicated by language barriers, cultural norms about taking medications, and lack of trust in Western medicine. Nevertheless, 78% of MSM of color survey respondents reported using Washington State's AIDS Drug Assistance Program, a rate 12% higher than for White MSM. The percentage of MSM of color who reported utilizing primary care and ADAP has increased steadily with each successive round of consumer surveys.

Although the Seattle EMA has completed its initial process of calculating unmet need using the University of California, San Francisco (UCSF) Unmet Need Framework, sub-population analysis to date has been limited to demographics based on sex, race/ethnicity and HIV/AIDS status. As a result, it is not possible at this time to use the UCSF model to quantify unmet primary care need for MSM, because data based on transmission risk is not available.

At present, quantitative estimates of MSM (including MSM/IDU) who have an unmet need for primary medical care are based on two assumptions: (1) an estimated number of 3,296 White MSM and 751 MSM of color reported to Public Health and presumed living with HIV or AIDS in King County and (2) the percent of 2003 MSM consumer survey respondents who either reported not receiving primary care, not having a T-cell count in the past year, or not having a viral load count in the past year. The percent of White MSM and MSM of color PLWH on the consumer survey meeting the "not in care" definition was applied against the overall number of PLWH in this sub-population in King County to develop an overall not-in-care estimate. Using this model, an estimated 425 White MSM PLWH are not in care (12.9% of the total White MSM PLWH population of 3,296) and 197 MSM of color PLWH are not in care (26.3% of the total MSM of color PLWH population of 751). The percentage of MSM of color who are not in primary care is double that of White MSM, suggesting that improved outreach to this population and linkage into the primary care system continues to be an ongoing issue.

Useful surrogate markers to quantify persons not in care come from the Seattle site of the CDC-funded Adult/Adolescent Spectrum of Disease (ASD) project. Data gathered in this project include information about persons who received a "late diagnosis" with HIV (diagnosed with HIV at the time of their AIDS diagnosis, or within three months of the AIDS diagnosis). This provides a picture of persons who were not in care for their HIV infection prior to receiving a diagnosis of AIDS. Results from the ASD project reveal that 66 out of 365 (18.1%) of White MSM and 79 out of 234 (33.8%) MSM of color PLWH who received an AIDS diagnosis during the period from 1996-2001 received a "late diagnosis" of HIV. In 2001, the last complete ASD reporting year, the percentage of late diagnoses in MSM of color was 42.3%, supporting the "not in care" data that suggest that increased efforts to refer and enroll MSM of color PLWH into primary care are necessary.

MSM focus group participants were all currently enrolled in primary medical care, and all had been to see their providers within the past six months. None reported major barriers to accessing medical care within the past five years, either for themselves or for their peers. However, several MSM participants noted that they had friends who they believed were at high risk for HIV but refused to be tested due to fear of learning the results.

B. Injection Drug Users

"There are probably many drug users living with HIV on the streets who are not connected to services and don't even know services are available. Most of them are in denial. They only learn that they are HIV positive when they get sick." (Substance use counselor)

1. Epidemiologic Profile

As in other cities in the Western United States, the number of cases of HIV and AIDS among drug injectors in King County is far lower than among gay and bisexual men. However, the percent of AIDS cases attributable to injection drug use (IDU) in King County has increased from 4% in 1982-1987 to 7% in 2000-2002.

Population sizes: There are an estimated 150,000 people in King County at increased risk of HIV infection because of illicit drug or alcohol abuse. About 15,000 of these of these are at increased risk due to drug injection practices.

Based on estimates from reported cases, up to 620 HIV-infected heterosexual IDU reside in King County. The estimated number of HIV-infected men who have sex with men and who also currently inject drugs is 800. Most of these men are thought to have acquired HIV through sexual transmission rather than by sharing of injection equipment. As of 12/31/2002, 344 heterosexual IDU and 465 MSM/IDU were reported to Public Health and presumed living with HIV or AIDS in King County.

Status and trends in HIV/AIDS cases: The first AIDS case among King County IDU males and females were reported in 1986. The proportion of cases attributed to drug injection among heterosexuals has increased from about 4% of cases in 1982-1987 to 7% in 2000-2002. While the number of male IDU (235) in King County reported living with HIV/AIDS is higher than the number of female IDU (109), the proportion of male cases whose infection was attributed to IDU is 5% versus 23% among females.

Injection drug use is a relatively more common route of HIV transmission for King County African Americans with HIV/AIDS (15% of living cases), Latinos/Latinas (9%) and Native Americans/Alaska Natives (27%) compared to Whites or Asian/Pacific Islanders (4% each).

HIV seroprevalence: There are approximately 620 HIV infections among the estimated 15,000 IDU residing in King County, which suggests that about 4% of all IDU are HIV-infected. In unlinked surveys conducted by Public Health, 1.5% of over 7,000 IDU entering King County drug treatment programs between 1988-1999 tested HIV positive. HIV prevalence did not change significantly over this time period.

IDU in treatment (such as those tested in the unlinked surveys) tend to be at lower risk of HIV then other injectors. In one study, HIV prevalence among IDUs recruited at the King County Jail and at needle exchange sites was more than twice as high as IDUs in treatment.

2. Service Trends

According to information from providers of services to injection drug using PLWH, the overall demographics of the population have changed in the past two years. The population of IDU PLWH is still primarily male (approximately 60% of clients served), although providers are seeing a substantial increase in the number of HIV+ female IDU. Approximately two-thirds of the male clients are White, with the rest almost equally divided between African-Americans and Latinos. Providers noted that their female IDU PLWH caseloads are equally divided among Whites and persons of color, primarily African American women and rising numbers of Native Americans. IDU respondents to the consumer survey were more likely to be persons of color than non-IDUs (49% versus 40%). Providers also noted that most of their clients are in the 35-45 age range, with increasing numbers of younger women seeking services shortly after being diagnosed with HIV.

Homelessness is also a major, and growing, problem in this population. Providers of chemical dependency services report that many of their IDU PLWH clients are homeless upon intake, and approximately 10% of their female IDU and between 25-50% of male IDU are currently or recently homeless. Survey respondents with substance use histories were also more likely as non-IDU PLWH to have been homeless in the past year (37% versus 26%).

Providers noted that well over half of their IDU clients have been in jail or prison, mostly for drug-related offenses. In many cases, incarceration is chronic, with clients returning to jail for repeat offenses. Consumer survey data support this statement, as IDU PLWH were significantly more likely than other consumers to have been incarcerated in the past year (16% versus 2%).

As noted in previous years, providers are seeing high rates of multi-drug use (both injectable and non-injectable) among their IDU clients, including rising rates of alcohol abuse. A major development in recent years is the growing number of women using crystal methamphetamine, a drug previously reported almost exclusively among White MSM. Among IDU respondents to the consumer survey, 34% reported using methamphetamine, 28% used cocaine, 15% used poppers or inhalants, and 13% used downers. Thirty-four percent of IDU also reported alcohol problems in the past year.

The number and percent of IDU PLWH who reported using substance use treatment has also risen during each of the past three rounds of surveys. In 1999, 32% of IDU survey respondents reported using substance use counseling services. In 2001, this figure rose to 42%. This year, 51% of IDU PLWH survey respondents reported using substance use treatment. These increasing figures are consistent with utilization reports from service providers, suggesting that case managers are becoming more effective in linking their clients to treatment assessments, enrolling them in one-on-one or group counseling, and entering them into methadone maintenance programs.

Providers continue to report seeing increasing percentages of their IDU PLWH clients who are both chemically dependent and mentally ill. Clinical depression and untreated bipolar disorder are very common in the IDU PLWH population. Crystal meth-induced paranoia is also relatively common. IDU survey respondents were significantly more likely than other PLWH to

report having been diagnosed with a mental illness (79% versus 48%). The percent of IDU survey respondents who reported mental illness has increased by 27% in the past two years.

Providers note that their MSM/IDU clients are generally seeking HIV-related medical care treatment earlier in their HIV disease than in recent years. The converse is true of heterosexual male IDU, who are entering care later in their HIV disease and experiencing higher morbidity levels. These men are also presenting with a higher rate of co-infections with Hepatitis B and C, cancers and other liver problems. Female IDU are also entering care later in their disease, particularly those who have not previously sought substance abuse treatment services.

3. Service Priorities

Injection drug using PLWH identified case management services as their highest service priority in 2003, followed by housing services, primary medical care, emergency financial assistance and oral health care (Table 22).

IDU PLWH were significantly more likely to identify several services as priorities compared to non-IDU consumers. Chief among these is case management, identified as a service priority by 67% of IDU versus 55% of non-IDU consumers. IDU consumers were also more likely to prioritize food and meal programs (43% versus 31%) and adult day health programs (18% versus 9%). Not surprisingly, IDU were five times more likely to prioritize substance use treatment, including non-injection treatment (25% versus 5%).

Table 22. Service Priorities: Injection Drug Users (n=87; 8 missing responses)

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Case management	58	67%
2	Housing assistance/related services	51	59%
3	Ambulatory/outpatient medical care	50	57%
4	Emergency financial assistance	46	53%
5	Oral health care	44	51%
6	AIDS Drug Assistance Program	43	49%
7	Food bank/home-delivered meals	37	43%
8	Psychosocial support	27	31%
9	Mental health services	26	30%
10	Substance abuse services	22	25%

5. Service Gaps

Injection drug using PLWH identified service gaps that were relatively similar to those reported by other populations. The number one service gap identified by injection drug using consumers

was emergency financial assistance, followed by housing assistance, psychosocial support, mental health services and substance abuse services (Table 23).

IDU survey respondents were less likely than other consumers to report unmet service needs. The only service that was significantly more likely to be seen as a gap by IDU was substance use treatment (13% versus 2%). This is consistent with the percentage of IDU survey respondents in 2001 who reported this gap.

Table 23. Service Gaps: Injection Drug Users (n=95)

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Emergency financial assistance	18	28%
2	Housing assistance/related services	11	17%
3	Psychosocial support	10	15%
4	Legal services	9	14%
5 (tie)	Mental health services	9	14%
5 (tie)	Substance abuse services	8	12%
7 (tie)	Referral for health care services	8	12%
7 (tie)	Alternative, non-Western therapies	7	11%
9 (tie)	Oral health care	7	11%
9 (tie)	Client advocacy	6	9%

Data from the survey were also used to quantify the unmet needs of IDU PLWH. This was accomplished by applying the percent of IDU (including MSM/IDU) identifying service gaps across the population estimate of 809 IDU reported to Public Health and presumed living with HIV or AIDS in King County. Analysis indicates that approximately 230 IDU PLWH in the Seattle EMA have an unmet need for emergency financial assistance; 140 have an unmet need for housing assistance (in particular, help paying rent); 120 have an unmet need for psychosocial support; and 110 have an unmet need for legal services and mental health services, respectively.

Providers of service to injection drug using PLWH frequently mentioned housing as the main service that their clients were unable to access. Providers noted a lack of affordable housing in general for low income persons in King County, particularly for their clients who are living at or below 100% of poverty level. The combination of active substance use and histories of incarceration often prove to be insurmountable barriers to successful housing, in many cases making clients ineligible for most forms of permanent housing.

5. Unmet Need for Medical Care

> *"When I stopped taking my meds and being compliant, my medical providers became not as responsive to me. When I became more engaged, they responded better. The harder I work at it, the better they work with me." (Former IDU PLWH)*

Data from the 2003 consumer survey reveal several differences between HIV-related health care status between IDU PLWH and non-IDU PLWH. Although IDU were slightly more likely than other consumers to be disabled by AIDS, IDU consumers were significantly more likely than non-IDU to be unaware of their T-cell counts (16% versus 9%) and viral loads (19% versus 11%). IDU respondents were also three times more likely than other consumers to report viral loads over 100,000 (12% versus 4%).

Significant differences emerged between IDU and non-IDU PLWH regarding the types of HIV-related medications they were taking. IDU were significantly less likely to report taking antiviral medications (63% versus 80%), protease inhibitors (37% versus 53%) and medications to manage HIV-related side effects (32% versus 42%). Although providers reported no actual difficulties for their IDU clients in accessing prescription medications, they did note significant adherence challenges in this population. Barriers to medication adherence include lack of housing and ongoing substance use. Several focus group participants (n=6) also noted that they were unwilling to continue their medication regimens due to problems with side effects.

Although the Seattle EMA has completed its initial process of calculating unmet need using the UCSF Unmet Need Framework, sub-population analysis to date has been limited to demographics based on sex, race/ethnicity and HIV/AIDS status. As a result, it is not possible at this time use the UCSF model to quantify unmet primary care need based on IDU status, because data based on transmission risk is not available.

At present, quantitative estimates of IDU (including MSM/IDU) who have an unmet need for primary medical care are based on two assumptions: (1) an estimated number of 809 IDU reported to Public Health and presumed living with HIV or AIDS in King County and (2) the percent of 2003 IDU consumer survey respondents who either reported not receiving primary care, not having a T-cell count in the past year, or not having a viral load count in the past year. The percent of IDU PLWH on the consumer survey meeting the "not in care" definition was applied against the overall number of PLWH in this sub-population in King County to develop an overall not-in-care estimate. Using this model, it is estimated that 188 IDU PLWH are not in care (23.2% of the total IDU PLWH population of 809). This estimate may be low, due to potential sampling bias on the consumer survey and the probability that lower percentages of respondents acknowledged substance use histories than is actually the case. It should be noted, however, the IDU participants in the 2002 consumer interview project reported rates of CD4 testing, viral load testing and HAART therapy that were equally as high as non-IDU respondents.

Useful surrogate markers to quantify persons not in care come from the Seattle site of the CDC-funded Adult/Adolescent Spectrum of Disease (ASD) project. Data gathered in this project include information about persons who received a "late diagnosis" with HIV (diagnosed with HIV at the time of their AIDS diagnosis, or within three months of the AIDS diagnosis). This provides a picture of persons who were not in care for their HIV infection prior to receiving a diagnosis of AIDS. Results from the ASD project reveal that 55 out of 197 (27.9%) IDU PLWH who received an AIDS diagnosis during the period of 1996-2001 received a "late diagnosis" of HIV. In 2001, the last complete reporting year, the percentage of late diagnoses in this population was 41.7%, suggesting that increased efforts to refer and enroll IDU PLWH into primary care are necessary.

Consumer focus group and provider interview data suggest that both heterosexual and MSM IDU displayed a lack of trust in the medical establishment and in HIV treatments, as well as concerns about being judged by care providers about their substance use. IDU PLWH may perceive that they receive a lower standard of care from medical providers due to their substance use. Lack of access to medical care did not emerge as a significant barrier for either group.